EXHIBIT 7

National Commission
on Correctional Health Care

Standards for Health Services in Jails

2018

J-A-09
important

PROCEDURE IN THE EVENT OF AN INMATE DEATH

Standard

The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths.

Compliance Indicators

1. A *clinical mortality review* is conducted within 30 days.
2. An *administrative review* is conducted in conjunction with custody staff.
3. A *psychological autopsy* is performed on all deaths by suicide within 30 days.
4. Treating staff are informed of pertinent findings of all reviews.
5. A log is maintained that includes:
   a. Patient name or identification number
   b. Age at time of death
   c. Date of death
   d. Date of clinical mortality review
   e. Date of administrative review
   f. Cause of death (e.g., hanging, respiratory failure)
   g. Manner of death (e.g., natural, suicide, homicide, accident)
   h. Date pertinent findings of review(s) shared with staff
   i. Date of psychological autopsy, if applicable
6. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

A *clinical mortality review* is an assessment of the clinical care provided and the circumstances leading up to a death.

An *administrative review* is an assessment of correctional and emergency response actions surrounding an inmate's death.

A *psychological autopsy,* sometimes referred to as a psychological reconstruction or postmortem, is a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the death. It is usually conducted by a psychologist or other qualified mental health professional.

Discussion

All deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

A clinical mortality review is conducted to determine the appropriateness of the clinical care provided and the effectiveness of the clinical policies and procedures relevant to the circumstances surrounding the death. Generally, a clinical mortality review asks at least three key questions: Could the medical response at the time of death be improved? Was an earlier intervention possible? Independent of the cause of death, is there any way to improve patient care?

The clinical mortality review may be conducted by a unit physician not involved in the patient's treatment, a central office or corporate physician, or an outside medical group.

The administrative review includes a review of the incident and facility procedures used; training received by involved staff; emergency response; and recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

A psychological autopsy for each suicide should be completed. The typical psychological autopsy is based on a detailed review of all file information on the inmate, a careful examination of the suicide site, and interviews with staff and inmates familiar with the deceased.

Corrective actions identified through the review process are implemented and monitored through the quality improvement program for systemic issues and through the patient safety program for staff-related issues. Refer to A-06 Continuous Quality Improvement Program and B-08 Patient Safety for information and guidance. Results of reviews are communicated to health staff for lessons learned to be shared with treating staff to prevent similar situations in the future.

A medical autopsy can often be helpful to health staff and should be requested for this purpose. When a medical autopsy is performed after all reviews are completed, the clinical and/or administrative reviews can be appended with applicable information from the autopsy report.

The requirement for a death review also applies to those deaths, whether natural or otherwise, that occur off-site while the facility is responsible for the inmate.